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## Voices from the Floor (January 2010)

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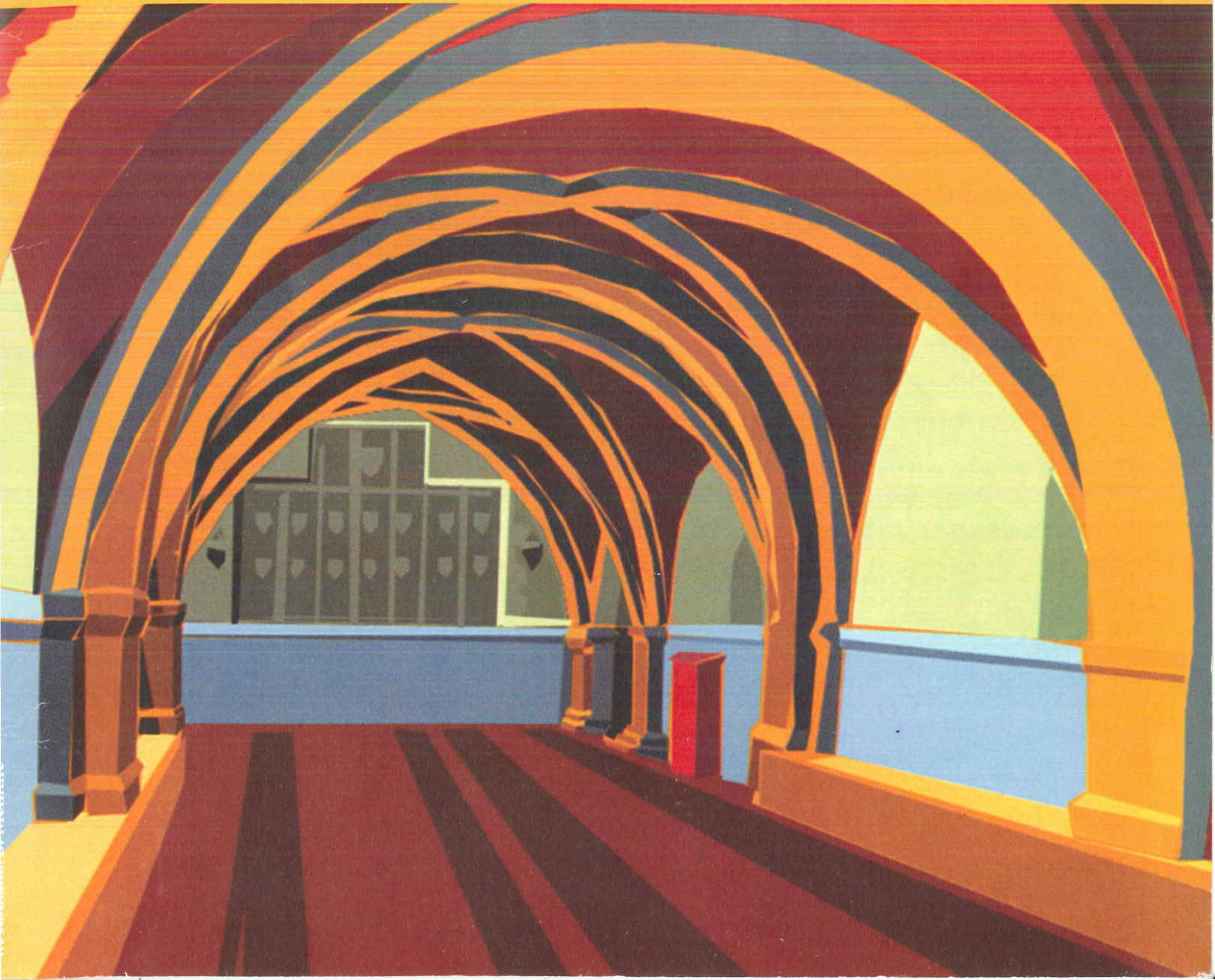
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# VOICES FROM THE FLOOR

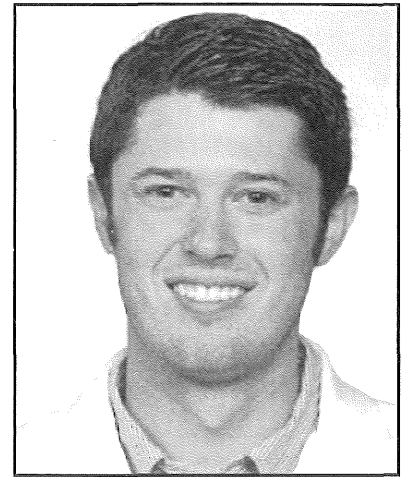
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January 2010



Dear Philadelphia College of Osteopathic Community,

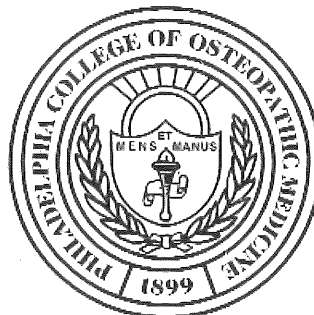
Our collective expectations of medicine both as physicians and patients have evolved over the past decades from an emphasis on palliative to now curative treatments. Research is fueled by the hope that science will ultimately outsmart nature. As physicians, we are influenced by the patient's expectations that our ability to prescribe and perform tests and procedures are our most powerful tools in our armamentarium against disease. Despite current emphasis on objective testing, we must never underestimate the impact simple gestures of humanism can have upon a patient's disease – gestures which are engrained within the principles of osteopathy.

In choosing a career in the healthcare profession, our days are, and will often, be hectic and filled with serious decisions. Yet, rarely are we afforded the opportunity to reflect upon the impact our decisions have on patients and their families. To promote constant growth and development as physicians, we have a responsibility to self-reflect upon our choices and the manner in which we treat our patients and our colleagues.

It is out this responsibility that I have reopened the PCOM anthology *Voices from the Floor*, a collection of stories and lessons in medicine and education from members of our community. This publication will be dedicated to a common goal – to promote a greater sense of self-awareness both as a student and a professional.

If you have a story you would like to share or a piece you would like to submit, do not hesitate to contact me.

Very Truly Yours,  
Justin Guthier, OMS-III



*This volume of*  
***Voices from the Floor***

*is dedicated to*

***Charlotte Greene, PhD***

*Thank you for all of your support and guidance.*

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## *A Close Call – Donald Halke III, MS-III*

**An Interview and Narrative written by Justin Guthier, MS-III**

Saturday nights for me usually mean quality time with my fiancé. She has been living in Pittsburgh for the past 2 years completing her Master's degree in Social Work at the University of Pittsburgh. I travel out to see her occasionally and we spend time together watching movies and going out for dinner. October 24th was no different than usual. As I was coming out of the movies with my fiancé, I turned my cell phone back on and found a voicemail from my Mom – it was 10:00 pm. I casually listened to the message as I started to get into the car when, I nearly dropped the phone from my hand. My ears heard but my mind could not process – “Donnie, you need to come home, your Dad is having a heart attack.”

The night before, my father and mother had gone out for a bite to eat. They had just finished eating some Maryland crab soup together when my father felt like he had heartburn. This was not an unusual occurrence for him since he does get heartburn from time to time. He took some Tums and aspirin when he got home, hoping it would go away. The pain increased in intensity throughout the evening. Thinking it was simply the heartburn, my Dad decided to sleep it off. Indeed, it did improve and by next morning he was feeling better. My Dad continued his normal routine that Saturday, doing work around the farm, plumbing and splitting wood. In the evening hours, the pain had returned and again increased in intensity, worse than before. At one point, my Dad was walking up a hill on our farm when suddenly he felt as if a 200 pound weight had been placed upon his chest. He could not move – he knew something was wrong.

My Mother took my father to the hospital where they did an EKG. The EKG yielded disheartening results – there was ST elevation, yet it was minor. Doctors concluded that the heart attack had started 18 hours previously after the dinner on Friday night. Unfortunately, the catheterization had to wait until Monday due to staffing issues. The decision was made to hold my father until then and manage him medically. That is when I received the phone call. I rushed back to Perry County where my father was hospitalized. It was a long car ride.

On Monday, the physicians performed the catheterization. There were three huge blocks in his coronaries – one block of 99%, another 85% and the last 75%. My family and I were stunned. My father

was only 50 years old and in better shape than men half his age. My father was an ultra-runner. For those of you who do not know, an ultra runner runs 100 mile races. He has finished 5 ultra marathons in the past three years. He has run over 85 marathons in his lifetime and finished at least fifteen 50-mile races. Both his mind and body are sharp. He is a certified public account for the state of Pennsylvania during the day and in the evening he maintains our sheep farm with the help of my mother. My father does not neglect his health either. He sees a cardiologist regularly to maintain healthy levels of cholesterol. His diet and lifestyle are so efficient; my father does not need to take any cholesterol medicines. At the time of his admission, my father's cholesterol levels were not off the chart – they were well within the healthy ranges for his age and current health condition – LDL 144, HDL 52 and his triglycerides were under 200. You can imagine the shock my family felt after we learned the severity of his coronary artery disease.

The only risk factor my father presented with was a significant family history. My father's father had had two heart attacks, both in his 40's. He eventually died of lung cancer since he was a chain smoker. His mother died at 54 from a massive heart attack. She too was also a long time smoker. Considering the history of heart disease in his family, my father undertook the healthiest lifestyle choices possible. He kept a good diet, did not smoke and had incredible endurance and exercise tolerance from all his running.

The doctors explained that my father's current condition was most likely not from plaque buildup, but rather, the doctors said it was “just” an incident out of the ordinary – that most likely plaque had erupted from somewhere else inside his body and had somehow lodged into his coronaries. Even today, they are still not sure, but the physicians believe it was most likely from my father's abdominal aorta.

Upon reviewing the catheterization results, it was decided that my father required a triple bypass. His surgery would be scheduled for the following Thursday of that week. In the days before the surgery, I spent as much time as I could with my father. Though I had confidence in the surgeon, I was nervous about my father's surgery because of the possibility that something untoward could happen. It was my father who was having the surgery done and I could lose him. My



family (mother and brother and extended family) were all incredibly supportive during this stressful time leading up to the bypass surgery. Despite his grave health conditions, my father did not exude any significant stress over those couple of days either. He knew that as a result of the heart attack, his left ventricular wall had suffered some minor damage, but the surgeon reassured him it was not serious. We both felt assured by the surgeon and cardiologist's report.

We understood from speaking with the surgeon early in the week, that the bypass my father would undergo was an everyday procedure that he had performed hundreds of times. He explained that a bypass is now considered routine surgery and although there can be side effects or mistakes, a lot of these issues had been worked out. The surgery was now the standard of care for patients like my father. So to say I was distraught and upset would not characterize me accurately; more appropriately, I was simply nervous with the "What ifs." My confidence in the surgeon prepared me for what was yet to come.

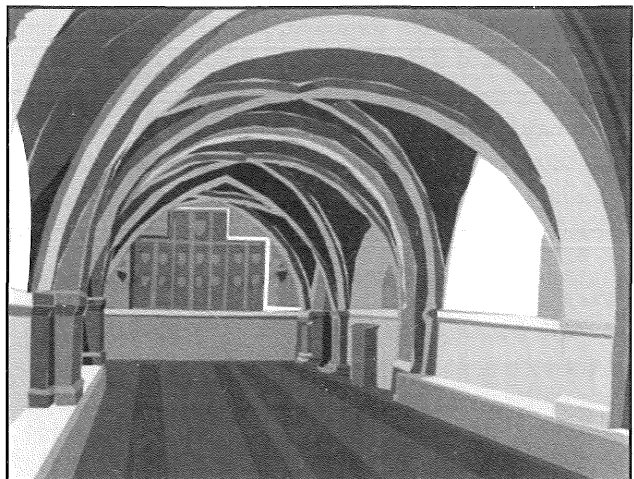
On Thursday, my father went into the OR for his bypass. When the surgeon opened my father's chest, he could barely tell that anything was wrong with his heart or that any damage had been done. His runner's heart had protected him while under the great deal of physical stress and cardiac ischemia. Upon investigating his arteries further, he found another artery which was over 65% blocked. The decision was made intra-operatively to perform a quadruple bypass. The surgery took four and a half hours. Post-operatively he had to take a three week course of ciprofloxacin for an incisional infection. Thankfully, the infection did not become too serious. If it had, they would have to use a flap from my father's pectoralis major muscle in place of his sternum, which would have to have been removed. Everything continued to move smoothly after his surgery and he returned to work on December 1st.

My father's near death experience was an eye-opening experience for me. Today, the age of 50 is very young. My father is still young to me. He lives his life in the best state of health – beyond what many people of any age are able to achieve. Running 100 mile races is no small feat. My father is proud of his health and his athletic abilities. Here I am at 24, and I would be happy to be as fit as my father. The most sobering aspect of this entire experience was the stark realization of my family's history of severe heart disease. If I have the same genetic background, here at 24 years old, I can look forward to having a heart attack when I am in my 40's or 50's. Compared to my father who works out like a crazy man, I just run two and a

half to three miles a day. I am a big fan of buffalo wings and blue cheese and eat more than my fair share and it is hard to imagine giving them up. However, I have started to eat healthier and have made exercise an even bigger part of my day that it was previously.

My experiences as a medical student definitely helped in getting thorough this entire tumultuous period of my life. You take a lot of things for granted when everything is going well. After second year, I was chosen to do my rotations for third and fourth year as a Geisinger Clinical Campus student. I had chosen to go to Geisinger so that I could be closer to home. My family and my fiancé are incredibly important to me. After this entire experience, I do not take "any of this" – meaning the opportunity to study to become a physician, to be with my father and the rest of my family, to become a husband in a few months – for granted. I do not take the fact that my life is falling into place for granted whatsoever.

You never know when your time is up. Make sure you take your education as a physician seriously. You have to be a scholar if you are a medical student. You have to keep learning about new procedures, new medicines – it is imperative that you stay on top of things to give your patient the best care possible. My father was the beneficiary of excellent training. I am seeking to replicate that dedication in my own education. This event has changed my view on life for the foreseeable future. I intend to eat better, exercise more. I now have a perspective on healthcare that I did not have before I began school back in 2007. Our chosen profession, more than any other profession, affects other people and their livelihood. You need to be there for your patients when something happens in their life.



# *Lessons from a Career in Medicine and Education – Rani Bright, MBBS*

## **An Interview and Narrative written by Justin Guthrie, MS-III**

Education has and always will be a major part of my life. I have been at PCOM as a professor for over 22 years, teaching Infectious Disease. But, before I was a professor, I practiced Pediatrics in India. I completed all of my education in India. The path to medical school in India is quite different than here in America. Students in India can start medical school immediately after high school. There are government sponsored schools and there are private schools. I applied at a time when there were only a few private medical schools – most were run by the government. I went to a government school where, at the time I was one of the few girls admitted. There is an age cutoff for admission to government schools as you cannot apply after 25 years of age. Seventy-five percent of the education is subsidized by the government in these schools, which is a great advantage as my parents only had to pay for 25% of my education.

The curriculum in India is based upon the British model. Training was very thorough, and testing was strictly by essay type questions; we had no multiple choice tests at all. We did not even know what a multiple choice question looked like! The essay questions emphasized thinking processes, creativity, writing and drawing diagrams. This model of testing allowed you to display how much you knew about a subject. We had no PowerPoint – and forget about scribe notes. Attendance was mandatory and the class sizes were small so all the professors knew everyone by their names. The big tests were administered by external examiners, and were essentially an oral test. To prepare for one of these you needed to know your stuff because the examiners could ask you about anything, and you had to be prepared to answer them. School was a very rigid and structured experience and testing was grueling. If 50% or more of students made it through the exam, then it was considered to be a good exam. There were no challenges, you just did the best that you could. Our degree was the MBBS or “Medicine Bachelor and Bachelor of Surgery.” It has been debated and suggested to change but the British system is very rigid. We get it upon graduation from a fully accredited allopathic medical college four and a half years of intense

training and completing one year of rotating internship.

In India training was not as technologically advanced as in America. It was very hands-on and emphasized good clinical skills. If I could bring any aspect of my medical training in India to PCOM, I would bring the emphasis on the physical exam. Today, there is a lot of reliance on testing, but performing a good physical and taking a thorough history are the hallmarks of a good physician. A good physician takes his time with the patient and tries to learn as much as possible through the physical and history. When you spend time with your patients it will make them feel appreciated. The time you spend is very important because when you get to know your patient, where they live, what their surroundings and family are like – you will be a better physician for that patient. This mentality directly correlates with the holistic message we teach here at PCOM. In India, there is a great deal of respect for the medical profession; students respect their professors and patients respect their physicians. When you are a physician, your patients, look up to you, you are important to them, do not ever forget that.

One experience I remember vividly during my medical education involved my own father. In my third year of medical school, my father came to me with an eye infection. I treated him with a penicillin eye-drop. Overnight, he developed a corneal ulcer and the next morning he awoke with great pain in his eye. We rushed him to the hospital where I met the head clinician of my school. She did not scold me as I expected, but simply explained that I was treating at a third year level and needed to act within those boundaries. My father recovered but I will not forget that experience. From that moment on, I knew I would always treat students who are trying their best with respect.

Unfortunately, India has poor vaccine coverage for its pediatric population. I have seen diseases that physicians here only read about in textbooks. I have seen diphtheria, meningitis from tuberculosis, children dying from dehydration, from diarrhea and malaria.

Smallpox is a very scary disease, but I have seen it many times. Tetanus, typhoid, rabies, leprosy are all diseases I have come in contact with in India as a physician. Although leprosy is not as intimidating a disease as you would expect to a physician, there is a social stigma against people who have leprosy. Their appearance is very intimidating to the general public. But as physicians, we know the pathophysiology and the route of transmission, so as a result we are not frightened and have no bias; we treat everyone with respect.

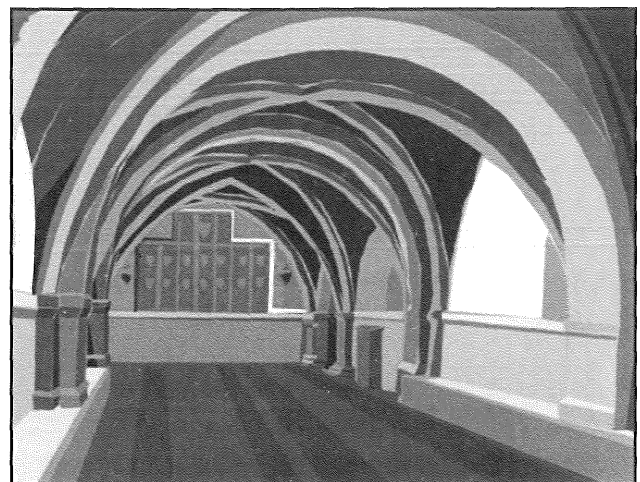
I have certified many pediatric deaths during my time, as many children die from infectious diseases. Certifying pediatric deaths was a very painful process. A parent brings you their child hoping that you will be their savior, hoping that you can save them. Then when you cannot and you have to tell them there is nothing left that can be done, it is very painful. I did this so many times, I began to become desensitized. It is the only way you can continue to do your job. I knew we did everything right, did everything we could, yet I wish I had been more receptive to the parents' pain and psychological heartbreak. Despite trying as hard as we could to save the children I still regret our circumstances and retain a bit of pain in my heart today.

When I married, I immigrated to America and spent many happy years as a stay-at-home Mom. As time went on, I began to miss my profession and took a job at MCP and then soon after took a position teaching infectious disease here at PCOM. It was easy to transition from pediatrics in India to infectious disease here because in India, everyone is an infectious disease clinician. Since you see so much infectious disease, it is part of your required training to learn how to treat common diseases like malaria and TB. This applies to all clinical disciplines – surgeons, internal medicine, pediatrics – since everyone sees these pathologies. This is why there is no infectious disease specialty in India; it becomes second nature for every physician to treat them. My favorite subjects to teach are emerging infectious diseases – H1N1, SARS and Bioterrorism. I have seen many students over the years. I appreciate students who come to class even though good students can learn on their own outside of class very well. A student really begins to show their potential when they can go out onto the floors and

apply what they have learned – not just take a test. Whatever I teach I hope they retain, but my proudest moments come during hospital days or when I see a former student out in the hospitals or the clinics and they say, “Dr. Bright – I treated TB” or “Dr. Bright, I saw cryptosporidium!” I feel very proud that they used my teaching to help another person and were able to shoulder the responsibility of that patient's care.

Dedication is a vital character trait as a medical student and a clinician. You can ask anyone who knows me. Every morning, I make it my business to go into the library and read my journals of interest. There is nothing more important than staying current in your field. I have nothing against textbooks, but journals provide you with the most current information. I guess that my training inspires me. In the British system there is a strong emphasis on independent reading and retention. My advice to students would be to choose two or three journals of interest to you as you progress with your training, and stick with them. Read every new issue and you will be at the top of your field everyday ready to treat your patients. Above all, this method of learning takes dedication.

For all of the students reading this, the difference between a good physician and superior physician is simple. Good physicians treat the disease as it appears in front of them. This is the band-aid approach. Superior physicians treat the root of the disease. A superior doctor thinks holistically and takes the whole patient into consideration. I have a fascination with public health. Public health is not sitting in class and taking notes – it is being out there and treating patients and analyzing disease conditions. Preventing disease is the big difference.



## *Wise Beyond Her Years – Danielle Cavanaugh*

### **An Interview and Narrative written by Justin Guthier, MS-III**

I have worked at the Philadelphia College of Osteopathic Medicine for over thirty five years. I began by working under Dr. Leonard Finkelstein, back in 1974 as a coordinator of the utilization review committee. He later became the President of PCOM. Soon after, I began working in the Psychiatry clinic. The clinic was located in the basement of Evans Hall, which was connected by a long tunnel to the City Avenue Hospital. I would interact and work with all types of people. Most were low income patients who needed to get their medications changed or regimens reassessed. In addition to the doctors, we had social workers and psychologists on staff. We could meet any needs that our patients had for their psychiatric health.

I enjoyed interacting with all the patients as they came in each day. Trust me – many, many characters made their way into my office. Part of the psychiatric clinic was the Neurosensory Unit. Those referrals would come from surrounding school districts for children who were having academic, social and personal difficulties. I would take a history from the parents and report the findings back to the group of social workers, psychologists and physicians and they would order the necessary testing. Working with parents and students was a phenomenal experience. Yet, of all the physicians I worked with in the Psychiatry unit, one doctor stands out in my mind.

Dr. George Guest was a real character. In those days, everyone smoked in the doctors' offices and Dr. Guest was no exception. No matter what time of day it was, he always had a cigar in his mouth. The charts smelled like cigars – everything smelled like cigars. Dr. Guest was the consummate physician. He was both a Psychiatrist and a Neurologist. He was, for a lack of a better word – a trip. But most importantly, he was a wonderful, caring man. Dr. Guest was an excellent lecturer as well. I would sometimes sit in his lectures. He could imitate – perfectly – the neurologic deficits of nearly every disease discussed in class. The students were enamored with his ability to teach and had a profound respect for him. Dr. Guest was also famous for serving his patients food at all different times of the day. If you were going to see him in the morning, he would have a little something to give you for break-

fast. If you had your appointment in the afternoon, he would have tea and crackers ready to share with you. Little sandwiches, coffee – his favorite snack was peanut butter and crackers. I loved working with Dr. Guest and with all the staff at the Psychiatry department. I worked there for thirteen years. Yet, new horizons were in store for me.

One day while at work, I was really upset with something – I cannot remember what it was, but I was really angry about the ways some situations and scenarios were being handled in the office. A gentleman was sitting in the waiting area. As he is sitting there, he sees that I am visibly frustrated and says “Boy, you’re angry?” He asks me what’s wrong and I go off on a tangent about how this “problem” needs to be addressed, how we should be doing this, that way – I go on for a while. As I am speaking with him, he calmly listens, nodding his head approvingly at everything I am stating. He says, “You know, I just started here, I’m new.” I said – “Oh really, you are the new . . .” looking for him to answer. He says, very matter of factly – “I’m the new CEO . . .” I froze. He continued on, “I will see what I can do about the problems you are telling me, but I am going to need a new assistant.” And that’s how I moved onto working for the CEO.

A few years later, Dr. Robert Berger, Assistant Dean of Clinical Education asked me to work for him. This is how I came to Clinical Education and I am now working with Dr. McLeod running this office. I have been here since 1991. I have seen many, many quality students come through my office. The students here are phenomenal kids, because, well you are all kids to me, of course. When we had the hospital, there were always white coats around. Now, not so much, but when we had the hospital there was a large white coat presence in my office and all around campus. I miss that. I make sure to keep this office open until 5:00 every day to give students on rotation the chance to come in and do their paperwork when convenient.

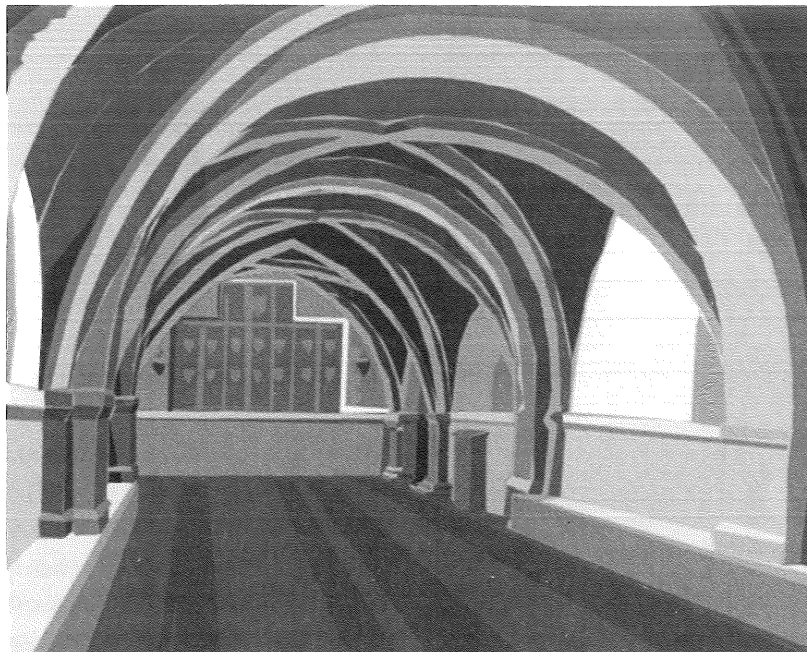
More so than years past, the students of today are a lot more rigid. I can see why – it is more competitive to get into medical school. Residencies are a lot

harder to obtain than in years past because the school enrollments are larger. Choosing rotations became easier with the Matrix – that made selection of rotations go a lot smoother. We used to officially call the Group representatives – Group leaders, but that sometimes led to problems. The biggest problems I have had with students have actually been when students within the same group do not get along and have disagreements. That is why we changed it from group leader to group representative – so the Representatives are, by their title, not held to a higher degree than the rest of their groups. A Group representative should be just like the other students but with a few extra responsibilities. We only had to impeach one group representative over the years and that was because he literally did not go to any group rep meetings and was not passing along any information to his group members. But overall, the groups have done very well during my time in this office.

Qualities of good students are the same as qualities of good physicians. Be kind and caring. Be an incredibly hard worker. Be careful what you say – your words are held to higher standards than everyone else. Most of all, have patience, for not only your patients

but everyone you work with. When you are on rotation, go into each rotation with an open mind. Try and learn from everyone: doctors, nurses, ancillary staff. See what you can get from each rotation, even if it is not your desired specialty. Never blow off your opportunity to learn. All the students are bright and when a student has problems on rotation, it is never because the work cannot be done. The problems are often related to a student who works alone or exhibits difficulties working with others. You cannot work alone in this field. You need to respect your attendings and work well with others to be a successful rotating medical student.

The most important lesson I have learned here at PCOM is the value of having patience as a professional. We are presented with many challenges which try our collective will. Students are stressed out and have a lot of pressure to succeed. I have learned that having had patience for “my patients” prepared me for this position. I do not mind taking the time to explain things and to keep students informed of their responsibilities. Take your time with your work, enjoy the journey, be polite to those around you – do not forget to read – and you will become a successful physician.



## *Perspectives on the Patient & Physician Experience – Alexander Nicholas, DO*

### **An Interview and Narrative written by Justin Guthrie, MS-III**

At first I thought it was just jet-lag. I had returned from a teaching trip to southern Germany on the 1st of October, 2008. On October 2nd, 2008, I did not feel like myself and did not even look like myself. That day, I was speaking Dr. Charlotte Greene, who visited me in my office to say welcome back. Dr Greene commented on how worn out I appeared. I honestly thought it was all just jet-lag.

I went home and was not feeling very hungry. I had a sandwich and soup for dinner and had a handful of trailmix as a late night snack. Over the years, I had known that nuts and seeds and trailmix all could upset my stomach. So when I began to have some pain, I tried not to pay it much attention. Soon though, the pain began to evolve into an epigastric knifelike pain. I tried to sleep it off, but at three in the morning, I awoke with horrible, just horrible epigastric pain. I stayed awake and tried to tough it out. That morning, as I was shaving, I doubled over –the pain had not gotten better – it was worse, much worse. I told my wife to call my office manager and cancel my patients because I could not go to work. A half hour later, I told my wife to call my doctor and inform him I was headed to the Emergency Room.

I have been to the Emergency room more than my fair share of times and know that there is the potential for a long stay. My experience that day was no different. All this time waiting and being medically managed in the ER, allowed me to ponder what exactly was going on inside my abdomen. When I was in medical school, I had had two abdominal surgeries, first was an exploratory laparotomy for an appendicitis and the other was for an intra-abdominal hernia. My bowel most likely had kinked over the years. My family physician ordered a Cat scan for a kidney stone which had shown a “weird link” of bowel a month before, so my suspicions were headed in that direction.

The attending surgeon that day requested that I get another CT scan to give the most current condition of my intestines. I was hesitant to receive the CT scan considering I had just had one a month before. The test required I drink Barium to image my abdomen properly. Ingesting the barium was no small task – especially for someone that is nauseous and in pain. Slowly and carefully I would take small sips of the barium to ensure that I did not vomit any back up. After 2-3 hours of small sips every 5 minutes, I had completed the barium and was ready for my scan. The CT scan technician rolled my gurney against the CT scan table, allowing me to slide into place. Making her routine preparations, she stated, “Alright, now I’m going to hook you up the IV contrast.”

Startled I retorted, “I thought I was only getting the oral barium – I don’t feel comfortable with the IV.”

With a firm tone she stated to me forcefully, “Look, the doctor ordered the test. They want to do the surgery, the surgeon is busy and trying to get you in at the end of the day. Do you want to have the surgery or not?”

“Hold on one second – if you could contact the surgeon, explain that I have had a CT scan and that I could get by without it,” I replied. She replied that she did not have time to wait for the surgeon to contact her and that she needed to do the surgery done now. Having been in the Emergency room all day, woozy on painkillers and exhausted from my pain, I apprehensively consented. I did not feel like fighting with the CT technician – I just wanted to get finished and get out of there.

A physician assistant entered my room in the evening to inform me that the results of my latest CT scan in the ER showed I had a link of bowel that had attached itself to the posterior surface of my right rectus muscle. Confident in my ability to self diagnose, I concurred with the PA and continued waiting for transfer to my hospital room.



After this particular experience in the ER, I have a new perspective on what it means to be admitted to the hospital. When I was getting worked up at Bryn Mawr Hospital, I saw the ER doctor for no more than 5 minutes. I had seen a surgical PA for just as long. I had arrived at Bryn Mawr at 9:00 am and was admitted at 8:45 pm – a long day by any standard. Being a patient in the Emergency room is a difficult and trying experience. You lay in an uncomfortable gurney all day, usually it is loud and difficult to rest. I was getting pain killers like Dilaudid so you feel discombobulated and woozy in unfamiliar surroundings. Vulnerability, anxiousness and frustration are all common feelings for any ER patient.

When I eventually met the surgeon, she was 7 months pregnant. She seemed confident and thought she would have an easy surgery. Unfortunately, she ended up getting a case that was a lot more than for which she bargained. I had a three and a half hour surgery. I lost 6 plus inches of bowel. Immediately post-operatively, I was on bowel rest and had a nasogastric tube inserted in my nose. I was feeling alright. I was not able to eat with the NG tube in, but I felt okay. Two to three days later, the surgeon came into my room and notified me, “Your creatinine is going up. I’m not sure why – we hydrated you a lot.”

My creatinine was going up and my general health was going down. I ended up putting on 50 pounds of third space fluid and my creatinine went from .9 - 3.6. Soon, I was moved to the ICU as my white count was rising precipitously. I got blood cultures upon blood cultures to try to figure out the cause of my infection. Dr. Michelle Hobson, a member of the OMM faculty, was of great assistance and support during this time. Dr. Hobson’s husband was the president of the Bryn Mawr Medical staff that year. He got other physicians on my case, clearly recognizing I had a problem beyond surgical management.

My initial hospital stay was quite long – I stayed in the hospital for over 2 months. I ended up having many additional x-rays and barium swallows for CT scans. My belly would repeatedly become distended with fluid, necessitating

paracentesis four times. Surgery was not an option for me since operating on my bowel would be like operating on wet tissue paper. I received IV antibiotics through a three valve pick line and was allowed to be discharged soon after. Around Thanksgiving of 2008, I was only able to eat small amounts of food. After eating I would, like clockwork, feel nauseous and vomit. This vomiting was nothing like the vomiting you have when you get a GI bug. My sickness felt like a mechanical dysfunction – I began to have projectile vomiting. I started to feel as if I was becoming obstructed. I would eat small amounts of food, then at 8 o’clock in the evening, I would have projectile vomiting. After I would vomit, I would feel like I could eat a whole cheesesteak – but I knew better. The surgeons knew I needed to come back into the hospital, but I pleaded that I would come back immediately after Thanksgiving. I felt as long as I went with just liquids, I could make it through. I tried to enjoy the holiday as best I could, but I went back into the hospital the next day.

Once again, I made my way to the ER at 9:00 am. Tests confirmed that I indeed was obstructed and surgery could be indicated. Medical management by NPO, NG tube and IV fluids could not decompress me. My urine protein and albumin were up. I had not healed well and had developed abscesses in my abdomen which need to be washed and lavaged out. I was operated on for the second time by Dr. Anthony Colletta. I felt confident with Dr. Coletta. I asked him to perform my surgery with the help of the first surgeon. Since she had been in my abdomen before, I felt she could assist Dr. Coletta in navigating through my adhesions and point out her work from two months ago. I have recovered slowly over the past year and am back at work, seeing patients and enjoying my life as a physician and professor of osteopathic medicine.

Having been in and out of the hospital multiple times over the past year, I have gained a unique perspective on the patient experience. When you are out of the hospital, all you can think about are ways to stay out of it. You want

to prevent medically what is happening, procrastinate like hell and not give in to your condition. Each time going back in is more stressful than the rest because you are not sure what the next step in the process will be. Being in the hospital can be awful. You cannot sleep. I still have not slept well for months, most likely because of many, many difficult nights. In the ICU, all you hear is beep, boop, beep, boop. You cannot get comfortable in any position except on your back. You have wires going in and out of you in many different spots. You give up your modesty after the fourth or fifth night.

You start worrying about your family, not so much yourself, but what if something really bad happens to you. I would worry about how my family was going to deal with serious complications. That consumed a lot of my thoughts. A couple times I was so sick, death did not feel like a bad option. I felt so terrible, but I could not forget my wife and children. One day when I was really filled up with fluid, I could not help to think of how my father looked when he died. When my father died, he was really filled up with fluid, he looked like two Michelin men put together. When I put on my 50 pounds I too began to look like a Michelin man. I looked at myself and I said, "Oh my god, I am dead," because that is how my father looked when he died. I remember telling someone, "Do not let my brother see me because that is how my father looked when he died."

Even after I was discharged from the hospital, the image of my poor health still stuck with many people. One night I was out with the Hobson's for dinner, and Dr. Hobson was talking about how seriously ill I was and how they all thought it was "close." I said to my wife, "Did they think I was going to die?" and she said, "- yeah." I can laugh at it now laughed because I only remember being really sick one time for like 6 hours – but I never thought I was going to like "die, die." But I guess I was pretty sick.

I got to the point where I hated being in the hospital. God bless the nurses – I had the most fantastic nurses. I had the best nurses's aides too.

Everyone acted like they loved me, I tried not to give them too much trouble, they would say, "Bother us – that is what we are here for" and I would reply that there were other people who were sick and needed help. I looked forward to them coming in to visit me. The hardest part was 9:00 - 10:00 at night till 8:00 the next morning. The number of staff is down and the nurses that do come in try to work in the dark. Night after night for two months, that was probably the most stressful thing because you do not want to think that the nurses could make a mistake because they are working the dark, trying not to awaken you.

When you are in the hospital, it seems like every third day you were getting another CT scan. I would have to take the barium drinks and it was so hard to keep them down, I would take a big sip with the straw and then wait 5 minutes and then take another sip. When you are sick or nauseous it takes 2-3 hours to get it down. Then you are carted down to cold areas and wait in a hallway, hoping that you do not vomit or have diarrhea. Then you wait to be picked up to go back to your room and hope that you are not forgotten about waiting in the hallway. You have a little blanket and gown. You really do lose all modesty. I tried to keep it light when I was in the hospital. Instead of the standard little pail they give you, I kept a huge bucket in my room, so that I could go down to the radiology department with this huge bucket. I could always get a smile out of people.

I did see one of my former students when I was in the hospital. He was an interventional radiologist. At this point, I had been in the hospital for many weeks. When I saw Stephan, he said, "Dr. Nick – what are you doing here? I saw this humongous, horrible chart and thought, 'nah – it's not him, and look, it's you!'" We exchanged pleasantries and he began to explain to me what he would be doing. I nodded approvingly after he explained the entire procedure. As he was about to begin, I looked at him, after having enjoyed his company and said with complete sincerity – "Stephan, I will do whatever you want me to do, but you have to promise me one thing – I do not want to feel any pain. Six weeks ago, you could

have poked me with a pitchfork, but now, I just can not take it. You have to promise me.” Assuringly, he nodded and continued with the procedure. He counted ‘one, two - ’ and on three the procedure was finished. I felt really lucky to have had a physicians like Stephan to help me. It reminds me that when you are working with patients, they are tired and cranky and can sometimes not be themselves. You need to have patience for your patients if you want to be a successful physician.

I tried not to broadcast the fact that I was a physician when I was in the hospital. My personality trait is not to be pompous – I wanted to be considerate with the nurses and respectful to the hospital staff. After a while people would pick up on the fact I was a physician, based upon the way I would say something with a little more knowledge. Nurses would playfully interject – “Hey-why didn’t you tell me that?” I simply did not want the staff to have the impression that I would say things like – “I AM DOCTOR ‘so and so’ and I expect this.” It really did not effect the way I was treated, but there is an increased level of respect when staff know you are a physician.

OMT was a big part of my hospital experience. One of our former students, a family practice resident who had worked with me in my office, would come into my room to do rib raising. After she ate dinner and would come back and do some more therapy on me. She was really nice and went above and beyond her responsibilities.

My daughter and her boyfriend who are both PCOM students also would come in and treat me. The department had a visiting clinician from Europe, Dr Jean-Marie Buckles, who came in to treat me one night. I had never met him – he came in with my brother and did a visceral oriented treatment that took my abdominal pain down significantly. He said, “I do a lot of this back home in the hospital.” He did a visceral release technique that I initially felt would do nothing, but later that night I did not have any belly pain. Earlier in the day I had had 7-8 out of 10 abdominal pain. My daughter treated my chronic cough by work-

ing on my thoracic inlet and in addition, working some chapman’s reflexes. My chronic cough would be relieved for extended periods of time with those treatments. My OMT in the hospital consisted of visceral techniques, rib raising, ENT treatments and chapman’s reflexes, all of which I found to be incredibly helpful.

It is important that you visualize what life is like for a patient in the hospital bed. When you are sitting in the three quarter position you get so tight. If someone puts their hands under your back, extending you and moving you around, working your traps and thoracic inlet, its feels great at that moment, regardless of the long term effects. Patients get a great deal of relief from rib raising and soft tissue techniques. Simple placement of the hands on the patient goes a long way. I have what I like to call the “Nicholas rules.” When someone under you does something and you see it work with your own eyes, you are conditioned to keep doing it forever. I had a lot of success with rib raising in treatment of post-op ileus and also with the singultus technique, which really does work.

As a physician I have a unique position of empowerment in terms of understanding what is happening to me as a patient. Information empowers patients and makes the hospital stay for them easier. Being in manipulative medicine for so many years I was rusty on a lot of the pathophysiology. I had to think , “Alright if I lose my ileocecal valve, this will be the outcome.” The inconvenience of being rusty on my pathophysiology bothered me the most. I would try to remember nephrotoxic drugs, what happens if I lose my bowel or what is my ileostomy going to be like. The more I started to think about these topics, the more upset I became. My daughter assuaged a lot of my anxieties. She would come in with her laptop would do medical searches and find out all the info I wanted to know. After she would leave, I would sit around thinking about our discussions, using the searches and my own medical knowledge I would go through differentials and when physicians would come in, I could help them rule out certain possibilities. I would

almost always be a day ahead of the physicians. I think most rational, educated people want to know their expected prognosis because there are a lot of issues you have to deal with if you have a bad outcome. It is important to make sure your patient knows all the possible outcomes within reason. The line between fanatical hysteria and withholding information is a fine line. You do not want to paint a picture of doom or get the patient needlessly worked up.

You always have to leave your patient with hope. With all of my patients who suffer from chronic pain, that is one lesson I learned from patient after patient. Hope is pretty powerful. In terms of malpractice, the better you communicate to your patient, the less likely you will have legal problems in the future. Empathy is a strong emotion, but it needs to be sincere. Your body language, your attitude, the empathetic foot you put forward, patients can realize when you do not care. You want your patients to believe you went into medicine to help others, then you will never get sued. If your patients feel that they matter to you, it is very hard to sue. A good example of strong qualities in a good physician is Dr. Anthony Coletta. Dr. Coletta had a strong attitude, which is necessary in surgery. However, Dr. Coletta did an excellent job. Every morning he saw me and gave me a complete physical himself. He did everything like you are taught in medical school. He did not rely on PA's or residents to provide him with information. After my physical, he would spend 5-10 minutes socializing with my family and me. Dr. Coletta is one of the few doctors who have such strong interpersonal skills – that is why I had such confidence in him. Dr. Coletta did the entire gamut. He was attentive to my physical, emotional and social needs. You had total confidence in the guy.

For all of the students out there, you should never be afraid of the patient. Treat your patient with respect and speak with confidence. Remind yourself that your patients are not really your friends. They want to have a connection with you but there needs to be limits. This is a fellow human being that you are dealing with. They are

scared and suffering. The patient, more often times than not, is mentally frazzled and emotionally and physically stressed. You unfortunately do not get the best of the patient when they are sick. Work with what they give you. When you say things – think about what you are saying. Communicate properly and effectively. If you are a student on rotation, only communicate things that students should be saying. Do not talk about diagnoses or tests that you are unfamiliar with and give your “opinion.” Always remember not to ask questions out loud to physicians that would make a patient feel uncomfortable.

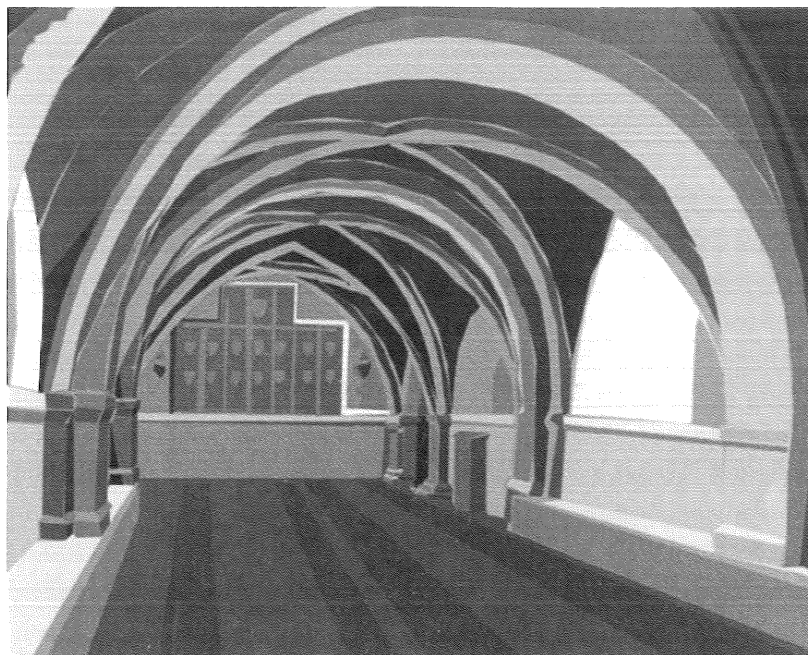
Always remember why you became a physician. There are going to be times where you feel burnt out. You will need to bite your tongue. If you feel yourself being callous, step back take a deep breath and go back to the feelings that brought you to a career in medicine. Even the most frustrating patients deserve respect and proper care.

At PCOM, we have naturally gifted and talented students becoming physicians. Obviously when you look at exceptional students, you look at numbers – MCAT's, COMLEX. What is really the difference between a 3.6 and 3.8? When I look at med school applicants, I look to be sure they are well rounded. In college, I was a liberal arts major. Even though it made my first year of medical school more difficult in comparison to some of my classmates, I became so incredibly personally enriched from majoring in history. To become a doctor, you have to have the intelligence. You need to be a little Sherlock Holmes and be a people person at the same time. If you are in this for the right reason – to help patients – then you are more than likely going to be a good physician.

My liberal arts education made interacting with different types of people easier for me than some of my science colleagues. From being a liberal arts major, I felt comfortable with knowing when I did not know something – I knew when to ask for help. Working on my weaknesses, became the mature and intelligent decision for a growing physician. During my intern year, I was

scheduled for an ICU rotation. I felt weak in Cardiology so I spent a month before hand on the cardiology service in preparation for my ICU experience. As a liberal arts major, if you know simple little things like ethnic backgrounds and little bits of information about certain ethnicities, you can make your patient feel more at ease. They are more likely to trust you and you will be more likely to gather a better history. Being well rounded, you will feel confident with different types of people and patients will become confident with you. Whenever I see that a medical school applicant has been a waiter in a busy restaurant for a number of years, I know that they are able to handle the stresses of working with people who have expectations and who require varying amounts of attention.

The last thing I would want students to consider is – think about what is positive or pleasant when you go to the doctor's office. What are you looking forward to that is pleasant? You probably will get your blood drawn, give a urine sample or even worse a stool sample. None of these are the most pleasant of experiences. As a DO, you can make patients want to come to your office. Be conversational, be pleasant, be someone who the patients want to come and see. You never want your patients to be afraid to go see their doctor. Always remember, there is no one who has an occupation like you. Maybe a teacher or a person who is heavily involved in community service, but there is no one as involved in the human experience as intimately as you.









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